Revised December 1, 2002

Reporting Abuse, Neglect or Misappropriation of Resident Personnel Property Or Facility Reported Incidents (FRI)

Principle

A nursing facility's investigations and related reports of abuse, neglect and misappropriation of resident property are thorough and timely.

Introduction

In order for a facility to receive federal reimbursement from Medicare and/or Medicaid, the facility is expected to follow certain protocols established by the Center for Medicare and Medicaid (CMS). One of those protocols requires reporting incidences of abuse, neglect and misappropriation of resident property, known as the Facility Reported Incident or FRI (42 CFR 483.13(c) and Tag 226 of Appendix P). It is apparent, however, that facilities are not fully complying with the CMS protocol.

The Center recommends that each facility review and revise, where appropriate, their policies, protocols and practices to ensure compliance with federal requirements. In addition, survey staff has been instructed to carefully adhere to Survey Protocol 5G, "Abuse Prohibition Review," of Appendix P to assure that facilities are in compliance with the requirements.

CMS memo S&C-02-20 reiterated the facility's responsibility in taking appropriate action to ensure resident safety from incidences of abuse and for filing timely and thorough incident reports.

A companion guideline has been developed giving direction for "Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personnel Property."

Our thanks to the Bureau of Quality Assurance of the Wisconsin Department of Health and Family Services for assistance in revising this guideline.

Definitions

"Immediately" means within 24 consecutive hours.

"Incident" means occurrences or episodes of staff misconduct and injuries of unknown origin.

"Staff" means any employee, volunteer, or contractor of the facility such as facility administrators, administrative staff, physicians, RNs, LPNs, nurse aides, podiatrists, dentists,

vocational therapists, beauticians, housekeepers, dietary, laundry, maintenance staff, and laboratory personnel.

"Staff misconduct" means (i) abuse of a resident, (ii) neglect of a resident, or (iii) misappropriation of a resident's property by facility staff.

General Rules

A. Every facility must ensure that its employees, contractors, volunteers, residents and nonresident personnel are knowledgeable about its staff misconduct reporting procedures and requirements.

B. When incidences of staff misconduct occur, a federally certified facility is required to self report those occurrences by filing an initial written report *immediately* to the Center and to any other state officials as required by state law[1], e.g. the Adult Protective Services Unit of the Virginia Department of Social Services.

Reports are to be faxed to the Complaint Unit, Division of Policy and Administration, of the Center at 804/367-2804.

C. Incidents must be reported to the Center when the facility has reasonable cause to believe that:

- The facility, or another regulatory authority, can name suspected staff; and
- The facility has sufficient evidence, or another regulatory authority could obtain evidence, to show the alleged incident occurred; and
- The incident meets, or could meet, the definition of abuse, neglect, or misappropriation as defined in the guideline "Facility Internal Investigations of Abuse, Neglect and Misappropriation of Resident Personnel Property."

When the facility concludes that these three conditions are true, the facility must conduct an internal investigation and report the occurrence to the Center. Refer to the "Mandatory Reporting" flow chart at the end of this guideline for assistance in determining if an incident must be reported to the Center.

D. If one or more of the following three conditions are true, then the facility must decide

[1] In addition to the Center, facilities are required to file reports with: i) the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, physicians, or other persons licensed or certified by DHP, ii) Adult Protective Services of the Department of Social Services for any suspicions of resident abuse, mistreatment or neglect; and iii) the appropriate local law enforcement authorities (i.e., police or sheriff's office) for any incident of resident abuse, mistreatment, neglect or misappropriation of personal property. For questions regarding reporting criteria of other state agencies or local jurisdictions, the facility should contact that particular agency or jurisdiction.

whether the incident must be reported:

- The facility cannot name the person(s) believed to have committed the occurrence, or the facility has less than reasonable[2] cause to believe another regulatory authority could identify the person(s) with some further degree of investigation; or
- The facility has less than reasonable cause to believe it has, or that any other regulatory authority, could obtain sufficient evidence to show the incident occurred; or
- The facility has less than reasonable cause to believe the occurrence meets one or more of the definitions of abuse, neglect, or misappropriation.

E. The facility is not required to report an incident when:

- It cannot name a suspect and believes no other regulatory authority could name a suspect; or
- The facility does not believe it has, or another regulatory authority could get, sufficient evidence to show the incident actually occurred; or
- The facility does not believe that the incident meets the definition of abuse, neglect, or misappropriation; and
- The facility cannot affirmatively rule out the incident as misconduct BUT the effect on the resident is minor[3].

The facility must conduct an internal investigation and document the incident but it is not necessary to report the incident to the Center.

I. After an initial written report of the incident has been filed with the Center, the facility must *thoroughly* investigate the incident and decide if an investigative report to the Center is necessary. A complete written report of the investigation must be filed with the Center *within 5 working days* of the incident.

Reports are to be faxed to the Complaint Unit, Division of Policy and Administration, of the Center at 804/367-2804.

J. Facility reports to the Center should contain sufficient detail to demonstrate that a thorough investigation was conducted including, but not limited to:

1. Date of the incident;
2. Names of resident, staff, or individuals involved;
3. Location of and description of the injury to the resident;
4. Location and description of the incident;

[2] According to reason; within sound or practical thinking; logical; within sound, sensible judgment.
[3] A minor effect of a resident is one that causes no apparent physical, emotional, or mental pain or suffering to a resident. Examples include: (i) missing candy and snacks, (ii) food missing from a resident's plate after the resident has finished eating, and (iii) mild profanities not directed at the resident.

5. Immediate corrective action taken to protect the resident from further injury;
6. Mechanisms in place to prevent recurrence of the incident, including date of review of facility policies and procedures; and
7. Documentation of report to Adult Protective Services, law enforcement, or the Department of Health Professions, as appropriate.

To assist facilities in filing timely reports, a "Facility Reported Incident" form and the "Mandatory Reporting" flowchart are attached to the end of this guideline. Use of the form is not mandatory for reporting purposes.

K. Do not include facility internal working papers when filing a report with the Center. Facility internal working papers should be kept on file for 5 years from the date of the incident and used by the facility as part of the facility's ongoing quality of care efforts.

Note: Documentation of the incident may also be necessary in the resident's medical record.

L. Decisions about further investigation by the Center vary according to several factors, including, but not limited to: i) the facility's written report, ii) the nature and severity of the incident, and iii) the frequency of such reports from a facility.

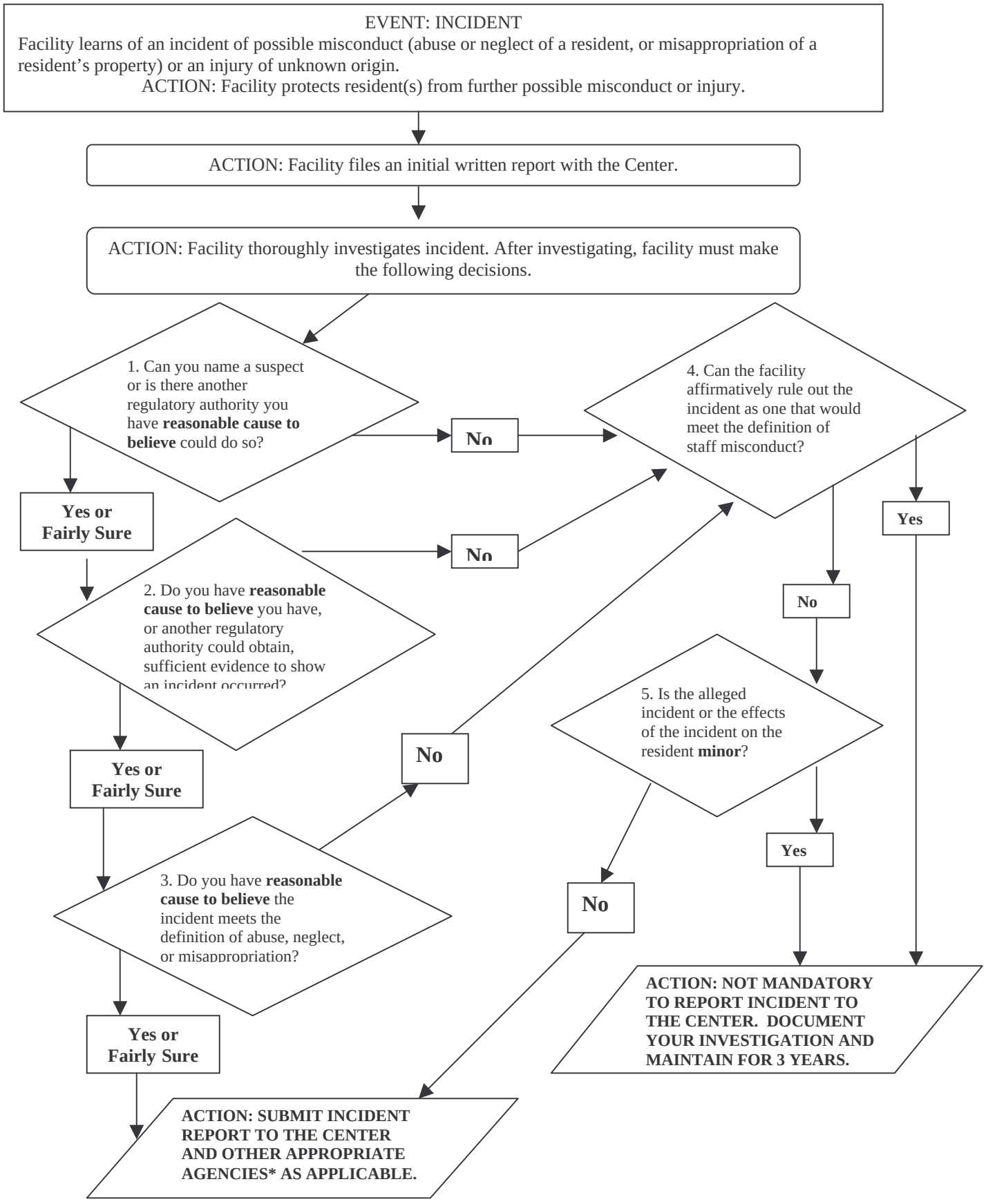
REPORTING OF ABUSE AND INJURIES OF UNKNOWN ORIGIN

INCIDENT:	**REPORT TO THE CENTER:**
INJURY OF UNKNOWN SOURCE	Yes
MISAPPROPRIATION OF RESIDENT PROPERTY	Yes
NEGLECT	Yes
MISTREATMENT	Yes
ABUSE:	
Resident-Resident (no physician contact/intervention)	Varies by situation
Resident-Resident (physician contact/intervention)	Yes
Nurse Aide-Resident	Yes
Other persons on the facility=s staff	Yes
Family/Visitor to Resident (no physician contact/intervention)	Varies by situation
Family/Visitor to Resident (physician contact/intervention)	Yes
UNUSUAL EVENTS	Yes

REPORTING TO CQHCCP/VDH:	**HOW:**	**WHEN**:
Initial Report of Incident	Faxed: 804/367-2804	Immediately
Results of Investigation	Written	5 Working Days

Reports to VDH/CQHCCP
Fax: 804/367-2804
Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection
3600 Centre - Suite 216, 3600 West Broad Street
Richmond, Virginia 23230

MISCONDUCT AND INJURIES OF UNKNOWN ORIGIN
FACILITY INVESTIGATION AND REPORTING REQUIREMENTS



* Other reporting requirements may also apply, e.g., local law enforcement, APS, DHP.